

Report of Touro Committee

Touro College has sought from the New Jersey Board of Medical Examiners a license to operate a private medical school in New Jersey. The Board is vested with the statutory responsibility to issue licenses to medical schools in this state pursuant to N.J.S.A. 18A:68-14. N.J.S.A. 18A:68-13, the successor to a 1924 provision, provides:

Every such school or college shall submit to the state board of medical examiners, with its application for a license, a statement verified by affidavit of the president or head master of the school or college showing the location of the school or college, the course of study pursued therein, the time required to complete the course, whether its students are required to attend the school or college in person, and if so, for what period of time, the number and qualifications of the instructors employed therein, and the facilities afforded for teaching the subjects in which instruction is intended to be given. The statement shall contain such additional information concerning the school or college as may be required by the board. The applicant shall present with the application a fee of \$100.00.

The school seeks from the Board preliminary or conditional approval so that it can initiate the accreditation process established by the Liaison Committee on Medical Education ("LCME"), with the understanding that ultimate licensure would be contingent upon full and continuing accreditation. To evaluate the submissions, Bernard Robins, M.D., former President of the Board, established a committee, to include several Board members and the Board's Education Director Mary Blanks, M.D. School representatives, including Touro President Bernard Lander, made an appearance before Drs. Robins and Board Member Paul Mendelowitz, M.D. on November 2, 2005. The committee asked the assembled representatives about the institution's financial preparedness, the physical facilities expected, faculty commitments being sought, and curriculum envisioned. The members present were persuaded that the school was intending to do all that would be required to achieve LCME accreditation. Although the committee members had initially been concerned that the project would be under-funded, and that the monies available would be insufficient to establish an allopathic school, it was represented at the meeting that the parent school was committed to make the project work and would provide the necessary financial support as needed. The committee sought additional assurance from Touro relating to its impact on tax-payer supported programs at UMDNJ. Via follow-up letters, Dr. Lander responded to the concerns expressed by the committee members and advised that the school had no intention of displacing students then in the training process.

Because of the board membership changes at the end of the year, new members needed to familiarize themselves with the matter. At the January full Board

meeting, the Board was briefed on the application and its authority to conduct a review of the application. The Board authorized the issuance of a letter to the LCME seeking guidance on the accreditation process and the documentation that entity would deem necessary to initiate a formal accreditation review. The entire application file was reproduced for the members of the Board's Executive Committee and a more expansive discussion was conducted at its meeting on January 27, 2006. This report represents a synthesis of the materials submitted up to this point and the research undertaken by Dr. Blanks.

The Factual Record

N.J.S.A. 18A:68-13 requires the applicant to provide:

- the location of the school;
- the course of study to be pursued;
- the time required to complete that course of study;
- whether attendance is required in person;
- the duration of the period that attendance is required;
- the number and qualifications of instructors; or
- the facility available for instruction.

Through its submissions, as supplemented by the responses provided at the November 2nd appearance, Touro has addressed, to the degree feasible at this juncture in the planning, all of these issues. The factual record reflects:

As to location: The school presently has a commitment from a donor, Florham Park Realty Associates, L.L.C., that would allow them to locate on a tract of land in Livingston, New Jersey. While it is anticipated that the school will be forging an alliance with Stevens Institute (that may involve the reservation of some medical school positions for Stevens students), and will share faculty in the basic sciences, the first two years of the program providing didactic instruction will occur at the Livingston campus, and will not necessitate travel to Stevens in Hoboken. Clinical training is expected to be within the northern New Jersey/metropolitan area. Consistent with trends in undergraduate medical education endorsed by the LCME, clinical experiences in ambulatory facilities and offices, especially for pediatrics and psychiatry, are envisioned.

As to the course of study, its duration and mode of instruction: The school plans to offer a traditional four year course of study (with two years of didactic training, followed by two years of clinical training) – personal attendance is necessary, although interactive techniques will supplement the curriculum. Touro's business plan envisions a class of 40 at first, increasing ultimately to a class of 100. There is a commitment to incorporate cultural competency instruction into the curriculum - and to support diversity in recruitment.

As to faculty: Although the school has been limited in its ability to identify specific instructors and affiliates at this stage in the planning, it has provided correspondence confirming exploratory discussions with Cathedral Healthcare Systems for clinical instruction. The hospitals in that system have sponsored students from other schools in the past and thus have an understanding of the responsibilities to be undertaken. (Earlier correspondence had mentioned St. Barnabas and Jersey City Medical Center as other possible sites.) Touro has maintained that it will not displace students of other schools in process; that pledge does not extend into the future and it is unclear as to arrangements that Touro is prepared to make to solidify its clinical site alliances. In addition, as noted above, there are ongoing discussions with Stevens Institute with regard to the sharing of faculty in the basic sciences. Also there has been some discussion of future joint degree programs with Stevens, at the graduate and undergraduate level. Materials relating to the California and Nevada osteopathic schools that Touro has established were submitted at the request of the Board to facilitate an appreciation of the scope and breadth of the expertise that must be represented in the clinical faculty. Those documents do include an expansive cadre of medical educators, although it is not clear as to the percentage serving in a full-time capacity.

As to facilities: The documents submitted reflect that the school has secured a commitment from a benefactor who has agreed to retrofit the present buildings (75,000 square feet) for the purposes of accommodating a medical school – with the requisite laboratories, lecture halls and offices. The benefactor has made a commitment of "up to" \$10,000,000.00.

Additional Factors

N.J.S.A. 18A:68-13 also includes one other requirement: "Such additional information concerning the school or college as may be required by the board." The committee focused on four additional issues:

- the school's financial preparedness,
- the adequacy of the educational experience (as demonstrated by ultimate LCME accreditation),
- the public need for another medical school in New Jersey and
- the impact that another school would have on New Jersey patients, students and institutions.

As to finances: The committee reviewed the financial projections in some detail and was satisfied that the parent institution is committed to operating the school in New Jersey and supporting it for an extended period of time, if necessary --for a period of up to five years. Touro has a proven track record of establishing viable educational programs throughout the world and has successfully founded two osteopathic medical school sites in the United States - in California and in Nevada. Two financial models were proposed, one contemplating financial self-sufficiency earlier than the other. The school, like all medical schools, is planning to rely on revenues from a variety of sources. Tuition

is expected to be in the range of other private medical schools (\$25,000 to \$30,000). The school will also pursue other donations and grants. No state funds will be sought or have been contemplated in the planning. LCME standards indicate that schools should be organized as non-profit corporations. While nothing in the materials provided squarely addresses this issue, the Nevada osteopathic school is so organized.

As to the accreditation process and the assurance that a quality medical education will be provided: Although the Board has never before reviewed an application for the establishment of a private medical school, the availability of the LCME process, which applies rigorous standards to fledgling schools, relieves the Board of the daunting task of evaluating first hand the specific readiness of the venture and offers considerable assurance that scrutiny will be given to the specifics. Dr. Blanks has been in contact with the LCME; the accreditation process includes a very thorough evaluation of finances and physical facilities -- especially at the outset. Schools seeking accreditation are required to complete a "database document", which reflects that the requirements for facilities are numerous and very specific. LCME also has clear standards to which schools will be held vis a vis recruitment, educational content, affiliate agreements, conflict of interests and other ethical concerns. Much of the detail concerning the school's proposed operation will need to be fleshed out during the accreditation process. Thus the committee would recommend to the Board that "such other information that the Board may require" should include a requirement that periodic updates be provided. The school represents that it will initiate the LCME accreditation process as soon as it receives preliminary or conditional approval from the Board. It has promised to keep the Board informed as to the progress of LCME review and to make available to the Board whatever documentation it produces in connection with that process. The committee reviewed the sample LCME database document and was satisfied that, when completed, it will provide comprehensive information about the facilities, faculty, curriculum and finances.

As to the public need for a medical school in New Jersey: Touro maintains that there is a clear need for another medical school in New Jersey. While there is no dispositive study substantiating the need, data available to the Board reveals that less than 12% of physicians licensed in New Jersey graduated from a medical school within the state. More than half of the physicians licensed in New Jersey were trained outside of the United States. Over a third of those who go to medical school in New Jersey stay in New Jersey to practice. Although the committee was inclined to believe that if more medical school students trained in New Jersey, they might be more likely to remain in the state for residency training and practice, it asked Dr. Blanks to survey the literature and report on "workforce" data that may be available. A summary of some relevant findings and data follows:

- **National Physician Workforce Overview** Currently the United States medical schools graduate approximately 17,000 physicians each year. The number of physicians entering residency training each year is 24,000. The difference of 7,000 is currently filled by 5,200 graduates of International medical schools, with the remainder of slots being unfilled.

- **Key Findings and Recommendations: Council on Graduate Medical Education ("COGME") 16th report'**

"When the midpoint of the projected range of future supply and demand is used, the nation is projected to face a shortage of about 85,000 physicians in 2020." (Demand based upon current use patterns.)

"When the midpoint of the projected range of supply and need is used, the nation is projected to face a shortage of about 96,000 physicians in 2020." (Need based upon current patterns with universal access.)

To address these shortages it has been recommended that there will need to be an increase in the total enrollment in U.S. medical schools by 15% from their 2002 levels over the next decade. This will require increased enrollment at existing medical schools and, potentially, the establishment of a number of new medical schools. Between 1982 and 2001 U.S. medical school enrollment increased 7% while the population grew 23% leading to a 13% net decrease in medical school students per capita. Between 2000 and 2020, the U.S. population is projected to increase by 18% while medical school capacity is scheduled to increase by only about 4%, leading to a further decrease in per capita medical students.' The recommended 15%

¹ Physician Workforce Policy Guidelines for the United States, 2000-2020 Council on Graduate Medical Education, January 2005.

² The COGME report identified the factors seen as influencing the future need for more physicians. The factors seen as contributing to the shortage of physicians include:

- Changing physician lifestyles with some younger physicians working fewer hours than their predecessors.
- Increasing use of physician services by those more than 45 years of age.
- The aging of the population with increased numbers of persons more than 45 years of age.
- Potential increase in non-patient care activities by physicians including research and administration.
- Change in practice patterns for physicians over the age of 50 years of age with a pre-retirement decrease in hours worked and earlier retirement patterns.
- Increased departures from practice due to liability concerns.
- Decreased hours worked by physicians in training.
- Possible decreases in immigration of graduates from foreign medical schools.
- Possible rise in "boutique medicine" and physicians limiting the number of patients on their panels.

increase would still leave the number of medical students per capita well below the 1980 level. The modest increase of 3,000 new U.S. medical graduates per year would allow the U.S. to reduce its current reliance on the approximately 5,200 international medical graduates who enter residency training each year as well as provide a base for responding to future needs. Decisions on medical school capacity need to be made now if the nation is going to be able to produce more U.S. medical school graduates in 2015 and beyond.

The number of physicians entering residency training each year should also be increased from approximately 24,000 in 2002 to 27,000 in 2015.

The Association of American Medical Colleges ("AAMC") in their February 22, 2005 Physician Workforce Position Statement echoes the COGME evaluation.³ Private correspondence with the Executive Director of the AAMC Center for Workforce Studies suggests that with further analysis it is possible that the 15% figure may be raised to 30% in the future.

Dr. Blanks has also gathered data relevant to the number of medical students in New Jersey, the positions in residency training programs and physicians in active practice.

Advances in genetic testing that could lead to increases in the use of services by at-risk individuals.

Medical advances likely to keep individuals with chronic illness alive longer without cure.

Economic expansion with increased resources available for medical care.

Countervailing factors which might serve to make anticipated shortages less dramatic were also identified:

Increases in productivity with improved technologies and information systems.

More effective utilization review and quality assurance efforts aimed at decreasing inappropriate or unnecessary services.

Increased supply and use of non physician clinicians.

Increase in costs and cost sharing.

Medical/technological breakthroughs that decrease service use

³ Association of American Medical Colleges Center for Workforce Studies, Key Physician Data by State, January 2006

- **New Jersey Medical Schools Matriculants 2005**

UMDNJ New Jersey	170	83.5% in state
UMDNJ RW Johnson	157	82.8% in state
UMDNJ SOM	<u>95</u>	
Total 2005	422	

- **New Jersey Residency Program 2004 and 2005**

Year	Number	Approved Positions	On Duty	Difference
2004	171	2676	2425	- 251
2005	178	2784	2510	- 274

- **New Jersey Key Physician Data on Active Physicians**² The term "active physicians" is defined by the AAMC as physicians who graduated from allopathic (M.D.), osteopathic (D.O.) and international medical schools and are involved in patient care, research and/or administration at least 20 hours a week. In New Jersey, there are 280 "active physicians" per one hundred thousand people. New Jersey ranks 10th in the nation in the number of active physicians in the population. On average, nationally, there are 245.6 active physicians per 100,000 people. Of the total number of active physicians in New Jersey, 12% graduated from a New Jersey medical school, compared to the national average of 29.6% of physicians in a state graduating from an in-state medical school. This means New Jersey ranks 39th of the 45 states which have a medical school, in the percentage of its active physicians graduating from its in-state schools. At the same time, 38% of the active physicians in New Jersey graduated from international medical schools, compared with the national average of 23.4 % of active physicians graduating from foreign medical schools. New Jersey ranks second nationally in the percentage of its active physicians in the state who graduated from foreign medical schools.

- **New Jersey Medical Students** There are 18 medical students - including students in both allopathic (M.D.) and osteopathic (D.O.) medical schools - per 100,000 people in New Jersey. Nationally, there is an average of 26.6 medical students per 100,000 people in the population in the states with medical schools. Based on this data, New Jersey ranks 33d in number of medical students in the state, when compared with the 45 states with medical schools. The proportion of current New Jersey physicians who did their graduate medical education training in New Jersey is approximately 48% - slightly higher than the national average percentage of physicians who are practicing in their state of training. The national average is 47.6 %. New Jersey ranks 18th nationally.

New Jersey ranks 28th among the 45 states with in-state medical schools in the proportion of its active physicians who graduated from New Jersey medical school. The national average percentage of active physicians who

attended medical school in the same state in which they practice is 39%. The proportion of physicians active in the United States who graduated medical school in New Jersey, who are currently practicing in New Jersey, is 37% who are currently practicing in New Jersey. (These percentages are approximate based on the charts reflecting key physician data by state.)

Of New Jersey citizens attending any United States allopathic medical school in 2004, approximately 46% attended allopathic medical school in New Jersey. This percentage of New Jersey allopathic medical students who studied in New Jersey medical schools, ranks 35th of the 45 states with medical schools.

- **New Jersey Accreditation Council of Graduate Medical Education (ACGME) Accredited Residency and Fellowship positions** New Jersey has approximately 28 residents and fellows per 100,000 population. With this number, New Jersey ranks 19th in the nation. Nationally, there are 34.3 residents and fellows per 100,000 population. This number reflects all accredited training positions.

International medical school graduates comprise 56% of the residents and fellows in training in New Jersey. The national average of international medical school graduates in graduate medical education training programs is 26.9%. New Jersey ranks first among the states; more of its residency positions are filled with international medical school graduates than any other state.

Of the active physicians practicing in New Jersey, 32% completed ACGME accredited residency or fellowship training in New Jersey programs. New Jersey ranks 29th nationally in the percent of its active physicians who completed ACGME training in-state. As a national average, 44.7% of active physicians in-state completed their ACGME residency or fellowship training in-state. The retention rate of active physicians in the United States who finished their residency or fellowship in New Jersey programs and who currently practice in New Jersey is approximately 48%, slightly higher than the national average of 47.6%.

As to the impact that the introduction of another medical school will have on the quality of the educational experience that UMDNJ and other students presently enjoy: While there has been a recognized trend to move more of the clinical training of medical students in the third and fourth years to outpatient facilities (particularly pediatrics and psychiatry), much of the training in core clerkships still takes place in a hospital setting. The introduction of more medical students into the hospital environments has the potential to impact those institutions, students matriculating at existing schools and patients. The committee continues to be interested in assessing whether New Jersey hospitals presently have the capacity to absorb more students, while assuring that they

receive the breadth and range of experience to provide a sound medical education foundation. Assuming that students are introduced into venues where there are none currently training, several impacts might be envisioned.

- The expanded opportunity for New Jersey citizens to attend medical school close to home is beneficial. Clinical clerkships will expose them to postgraduate training programs that are local. This exposure could result in increased numbers of New Jersey educated medical students matriculating in New Jersey residency programs. Further it is likely that some retention of these trainees as practitioners in the state could be expected.
- In addition, the presence of medical students may enhance the training environment . Where clerkships are done in association with residency training, it is estimated that 25-50% of clinical teaching for medical students is done by residents. Clerkship directors have studied, and the literature appears to support, that short "teaching skills programs" for residents have been shown to increase perceived effectiveness in teaching of medical students.⁴ Moreover, resident and attending teaching methods are different and complementary, enhancing the medical clerkship experience.⁵ There is a positive correlation between teaching medical students and learning for residents involved in teaching.⁶

But some less positive impacts might also be realized:

- While Touro is proposed as a private institution the nature of medical training involves significant costs to the institutions at which training takes place. The clerkship training experience -- whether outpatient or in a hospital or other licensed facility -- and the training of medical students generally decreases efficiency of operations. Since these facilities are publically supported to some degree either through Medicare, Medicaid or other non profit status, some of the cost of this "private education" may be borne by the public. Also, once the program is established and found to benefit the state, requests for financial assistance for student support, public -- private research or other needs might be expected.

⁴ Hammoud MM., Teaching residents how to teach improves quality of clerkship, AM J Obstet Gynecol, (Nov. 2004);191(5):1741-5

⁵ Tremonti L.P. et al, Teaching behaviors of residents and faculty members. J Med Educ (1982) 57:854-859

⁶ Seely A.E., The teaching contributions of residents. CMAJ (1999) 161 : 1239-1240

- Moreover, the nature of a private institution may not be public service mission driven. The existence of such an institution on the competitiveness of existing institutions with a charitable mission focused on the medically underserved population of the state should be considered carefully.

Committee Recommendation

After review of all of the above factors, the committee is inclined to conclude that Touro's plan for the establishment of a private medical school in New Jersey would provide a quality medical education to students. It was persuaded that Touro has the commitment to meet the LCME standards and to assure that sufficient financial resources are made available to ensure success and ultimate self-sufficiency. It is satisfied that the LCME process on which the school would be embarking is rigorous and comprehensive. The committee however continues to seek a better understanding of the impact that the creation of a private medical school in New Jersey will have on its institutions, students and patients, and it welcomes additional information on these points from Touro at the time that the full Board gives consideration to the application for provisional or conditional license approval. Interested entities, organizations and persons are being alerted to the matter and invited to offer data and comment, as well.